

ATTACHMENT 4

Sample CMS 1500 claim form for county-owned community support program services

HEALTH INSURANCE CLAIM FORM																																																																																																														
<div style="display: flex; justify-content: space-between;"> <div> <div style="display: flex; align-items: center;"> <input type="checkbox"/> PICA </div> <div style="display: flex; justify-content: space-between; font-size: small;"> <div> 1. MEDICARE <input type="checkbox"/> (Medicare #) P 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Im A 5. PATIENT'S ADDRESS (No., Street) 609 Willow CITY Anytown STATE WI ZIP CODE 55555 TELEPHONE (Include Area Code) (xxx)xxx-xxxx </div> <div> 3. PATIENT'S BIRTH DATE MM DD YY MM DD YY SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F 6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> 8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/> </div> <div> 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 1234567890 4. INSURED'S NAME (Last Name, First Name, Middle Initial) 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (INCLUDE AREA CODE) </div> </div> </div> </div>																																																																																																														
<div style="display: flex; justify-content: space-between;"> <div> 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) OI-D a. OTHER INSURED'S POLICY OR GROUP NUMBER b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> c. EMPLOYER'S NAME OR SCHOOL NAME d. INSURANCE PLAN NAME OR PROGRAM NAME </div> <div> 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE </div> <div> 11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d. </div> </div>																																																																																																														
<div style="display: flex; justify-content: space-between;"> <div> 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____ </div> <div> 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____ </div> </div>																																																																																																														
<div style="display: flex; justify-content: space-between;"> <div> 14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 19. RESERVED FOR LOCAL USE 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. L 295.60 2. _____ 3. _____ 4. _____ </div> <div> 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY 17a. I.D. NUMBER OF REFERRING PHYSICIAN 20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER </div> </div>																																																																																																														
<table border="1" style="width: 100%; border-collapse: collapse; font-size: x-small;"> <thead> <tr> <th rowspan="2"></th> <th colspan="3">A</th> <th rowspan="2">B</th> <th rowspan="2">C</th> <th rowspan="2">D</th> <th rowspan="2">E</th> <th rowspan="2">F</th> <th rowspan="2">G</th> <th rowspan="2">H</th> <th rowspan="2">I</th> <th rowspan="2">J</th> <th rowspan="2">K</th> </tr> <tr> <th>From</th> <th>To</th> <th>MM DD YY</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>11</td> <td>11</td> <td>03</td> <td>05</td> <td></td> <td>H0039 UB</td> <td>1</td> <td>XX XX</td> <td>4.0</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>2</td> <td>11</td> <td>14</td> <td>03</td> <td>21</td> <td>28</td> <td>12</td> <td>H0039 HM</td> <td>1</td> <td>XXX XX</td> <td>12.0</td> <td></td> <td></td> <td></td> </tr> <tr><td>3</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>4</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>5</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>6</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table>											A			B	C	D	E	F	G	H	I	J	K	From	To	MM DD YY	1	11	11	03	05		H0039 UB	1	XX XX	4.0					2	11	14	03	21	28	12	H0039 HM	1	XXX XX	12.0				3														4														5														6													
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<div style="display: flex; justify-content: space-between;"> <div> 25. FEDERAL TAX I.D. NUMBER SSN EIN 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) I.M. Provider MMDDYY SIGNED DATE </div> <div> 26. PATIENT'S ACCOUNT NO. 1234JED 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) </div> <div> 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # I.M. Billing 1 W. Williams Anytown, WI 55555 87654321 PIN# GRP# </div> </div>																																																																																																														
<div style="display: flex; justify-content: space-between;"> <div> 28. TOTAL CHARGE \$ XXXXX 29. AMOUNT PAID \$ 30. BALANCE DUE \$ XXXXX </div> </div>																																																																																																														

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)